Accounting of Disclosures Request Form

Name	Request Date
Mailing Address	Date of Birth
City/State/Zip	Medicaid ID# or Soc. Sec. #

Disclosure Time Period

I am requesting a list of disclosures made relating to my health information for the following time period:

From: _____ To: _____

I am requesting the Department of Health and Hospitals provide a list of disclosures relating to my protected health information. I understand that:

- The list is free one time in any 12-month period. A fee may be charged for additional lists in the same 12-month period.
- Disclosures made before April 14, 2003, will not be included.
- Disclosures made more than six years before my request will not be included.
- Only disclosures not relating to treatment, payment, or health care operations will be listed.
- Disclosures that I have authorized will not be included.

I acknowledge that I have read both pages 1 and 2 of this form.

_____ _____

Signature of Individual or Personal Representative Authorized by Law — Date

_____ _____

Signature of Witness *(If signed with an "X" or mark)* — Date

For DHH Use Only

Date received: _____ ❒ **Accepted** ❒ **Denied** ❒ **Delayed**

If **delayed**, list the date the accounting will be provided: _____

Comments:

_____ _____

Signature & Title of Agency Representative — Date

Your Rights to an Accounting of Disclosures

- You have a right to request an accounting of disclosures made of your health information.

- You have a right to have an answer to your request within 60 days. If there are delays in getting you the answer, you will receive a notice in writing. The delay cannot be more than 30 days.

- Your first request for an accounting of disclosures in a 12-month period is free. You may be charged for additional requests in the same 12-month period.

Your Right to File A Privacy Complaint

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how DHH has used or disclosed information about you. Your benefits will not be affected by any complaints you make. DHH cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful. Your Privacy office contact is:

State of Louisiana
Department of Health and Hospitals

INSERT PROGRAM OFFICE INFORMATION HERE
INCLUDING EMAIL ADDRESS

Phone: ( )
E-mail: Privacy-DHH@la.gov